ANNUAL REPORT and FINANCIAL STATEMENTS

2008/2009

Ontario

Ontario Health Quality Council

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Letter of Transmittal

September 28, 2009

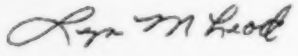
Honourable David Caplan
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

On behalf of the Ontario Health Quality Council, I have the honour to present you with our 2008/2009 annual report. The report reviews the Council's performance for its third full year of operations and provides audited financial statements.

Thank you for your support of the Ontario Health Quality Council's work.

Respectfully,



Lyn McLeod
Chair, Ontario Health Quality Council

Mandate

The Ontario Health Quality Council (OHQC) was established in September 2005 under the *Commitment to the Future of Medicare Act, 2004*. The Council is an Operational Service Agency that reports to the Minister of Health and Long-Term Care.

Section 4 of the *Act* sets out OHQC's mandate:

(a) To monitor and report to the people of Ontario on:

  (i) Access to publicly funded health services

  (ii) Health human resources in publicly funded health services

  (iii) Consumer and population health status

  (iv) Health system outcomes

(b) To support continuous quality improvement

Section 5 of the Act requires OHQC to deliver a report each year to the Minister on the state of the health system in Ontario — we call it *QMonitor: Report on Ontario's Health System* — as well as any other reports the Minister requires.

Strategic Plan

MISSION

A trusted, independent voice dedicated to informing the public about the quality of its publicly funded health system. A catalyst for improving our health system and our population's health.

VISION

A high-performing health system committed to continuous quality improvement. A system that is there for you when you need it, and involves you in maintaining and improving your own health.

STRATEGY 1
Engaging and reporting to the public

STRATEGY 2
Promoting alignment of indicator frameworks

STRATEGY 3
Building capacity for quality improvement

STRATEGY 4
Developing leadership in quality improvement

VALUES

• Passionate about quality improvement • Objective and guided by evidence
• Public involvement • Health system partnerships • Embracing diversity

2008/2009 Performance Highlights

The ultimate aim of public reporting is to stimulate improvement. The four strategies depicted on the previous page work in combination to ensure that OHQC's reporting is based on sound performance measurement and is integrated with action to improve quality. In fiscal 2008/2009, OHQC was able to report more deeply and broadly on the quality of Ontario's publicly funded healthcare system. OHQC also began to build its capacity to promote the alignment of performance measures across the health system and provide direct support for quality improvement. Responding to a specific request from the Minister of Health and Long-Term Care to measure and publicly report quality of care and resident satisfaction in long-term care homes, OHQC has focused all four of its strategies on this sector. In December 2008, the Minister added home care reporting to OHQC's tasks.

Engaging and reporting to the public

OHQC's yearly report — *QMonitor: Report on Ontario's Health System* — assesses the quality of Ontario's publicly funded health system relative to nine attributes of a high-performing health system. These attributes are the extent to which the system is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.

For effective reporting, the public must have confidence in OHQC's independence and full disclosure. OHQC takes great pains to ensure that the information it presents is accurate, objective and evidence-based. It does this by partnering with highly respected researchers, choosing performance measures and data sources that are valid and reliable, and ensuring the content receives thorough scientific review. OHQC continues to work with the Institute for Clinical Evaluative Sciences as its primary research partner. In 2008/2009, OHQC worked with additional well-regarded organizations in specialized areas of measurement, such as the Institute for Safe Medication Practices, the Institute for Work & Health, the Project for an Ontario Women's Health Evidence-based Report (POWER), Cancer Care Ontario, the Ontario Agency for Health Protection and Promotion and the Commonwealth Fund.

OHQC released the 2009 edition of *QMonitor* on June 9, 2009. It included more than 130 performance indicators grouped into 34 themes. One of the most valuable additions to this year's report was the section featuring 10 success studies, which provided documented evidence of how certain healthcare organizations were able to achieve a measurable improvement in a theme area. OHQC's communications strategy, while aimed at the general public, sharpened its focus on board members of healthcare organizations as a target audience and challenged them to apply the learnings from the success studies in their own organizations.

The Minister of Health and Long-Term Care recognized OHQC's success in public reporting by asking us to tackle two more specialized areas of reporting. In June 2008, he announced that OHQC would measure and publicly report quality of care and resident satisfaction in long-term care homes. Six months later, the Minister asked OHQC to do the same for home care services.

In June 2009, OHQC launched an initial report on province-wide quality and satisfaction in long-term care. We distributed close to 12,000 copies to long-term care residents and their families through Ontario's 600+ homes, to local health integration networks (LHINs), to community care access centres and other organizations serving the senior population, and to Ontario Members of Provincial Parliament (MPPs). By November 2009, OHQC expects to launch the first generation of a website to report on individual long-term care homes and community care access centres. With the Ministry's plan to implement the MDS information system across all long-term care homes, Ontarians should be able to find and compare information on quality and satisfaction in each facility in the province by November 2011.

Promoting alignment of indicator frameworks

Improving quality of care requires action at both the policy level and the care delivery level. The policy level typically involves policy makers who develop regulations and make decisions about how to allocate resources. The care delivery level typically involves managers and/or front-line providers and users of the system whose hands-on care decisions are informed by proven clinical best practices.

OHQC advocates for and collaborates with the Ministry, LHINs, healthcare provider organizations, researchers and other healthcare stakeholders to develop indicator frameworks and align measurement with strategy. Ideally, these publicly reported indicators drive health system management decisions. OHQC kicked off its work in this area with the July 2008 release of a white paper entitled *Accountability Agreements in Ontario's Health System: How Can They Accelerate Quality Improvement and Enhance Public Reporting?*

To address the focus on long-term care homes, OHQC worked with a panel of scientific experts and collaborated with two other bodies that report quality indicators for long-term care — the Canadian Institute for Health Information and the Ministry's Performance Improvement and Compliance Branch — to ensure consistency in the choice and application of measures. Building on this work, OHQC is participating in the development of indicators for the service accountability agreements the LHINs and long-term care facilities will enter into by April 1, 2010.

With specific direction to report on satisfaction with long-term care and home care, OHQC has initiated consultations across Ontario's health sectors and with other provinces to agree on a core set of questions that will enable benchmarking and comparisons across sectors and jurisdictions. OHQC is also collaborating with the Ministry and others on initiatives to promote alignment in performance measurement, such as developing a consistent provincial definition of "alternate level of care" (ALC) and commissioning a review of existing national and international frameworks for measuring healthy work environments. The results will be used to promote and align a common set of themes and core indicators across different healthcare sectors.

Building capacity for quality improvement

Leading healthcare systems around the world invest heavily in their staff to develop the skills required to use quality improvement science and tools. Quality improvement also depends on connecting different quality improvement teams working on similar topics so they can effectively share their experiences on how to implement change. OHQC's mandate is to serve as a catalyst for quality improvement and, as such, our chosen strategy has been to develop quality improvement resources and cultivate partnerships to support structured quality improvement activities.

In response to a request from the Ministry's Performance Improvement and Compliance Branch, OHQC formed a partnership with the Branch, the Registered Nurses' Association of Ontario and the Canadian Association of Wound Care to offer a collaborative (a structured series of quality improvement learning sessions and action periods that spanned a one-year period) to reduce the prevalence of pressure ulcers in long-term care homes. OHQC's role in this partnership was to provide expertise in measurement and quality improvement methodology and to contribute to the collaborative planning process.

In the past year, OHQC added to the inventory of quality improvement tools on our website. Accessible online in an interactive format to promote easy use by teams, these tools can be customized to meet specific team needs. Our new resources include:

- *QImprovement Guide*, which provides the foundational knowledge necessary to start improvement projects and features quality improvement project cases, the Quality Improvement Model for Improvement, examples of quality improvement methods and templates of quality improvement tools
- *QImprovement Guide for Long-Term Care*, which contains examples, forms and terminology specific to the long-term care sector
- *Module 1: Access and Module 2: Efficiency*, which help to develop knowledge and skills in balancing supply and demand for health services

As we engaged long-term care stakeholders in discussions about their quality improvement practices, it became clear that there was a need for quality improvement training. OHQC subsequently developed a two-day quality improvement curriculum for this sector and provided training to 200 long-term care staff from across the province. Consistent with our partnership approach, OHQC invited the Registered Nurses' Association of Ontario to co-present this training.

OHQC responded to an invitation from the Ministry's Quality Improvement & Innovation Partnership to serve as faculty for its collaborative. We provided expertise in the areas of access and efficiency and focused training in concepts related to "advanced access" to 130 participating primary care teams and practice facilitators.

OHQC also responded to numerous requests to partner with organizations and support quality improvement training efforts, including from the Ontario Hospital Association, the Canadian Institute for Health Information and the South West LHIN.

Developing leadership in quality improvement

Ideally, quality improvement leaders monitor results for indicators that are important to quality. These leaders also set targets for improvement and develop plans to achieve these targets. At the board level, for example, this may mean setting global targets to improve an institution's quality indicator scores, allocating funds and other resources to support this improvement, setting aside 25% of board meeting time to review quality indicator performance and holding management accountable for the results.

OHQC recognized that the focus on public reporting within the long-term care sector would increase interest in strengthening quality improvement activities in that sector. So we brought together stakeholders, who mobilized towards a common vision and approach and submitted a proposal to the Minister of Health and Long-Term Care. This proposal outlines a strategy that will align leaders' quality efforts and leverage each partner's contribution towards a larger outcome. Leadership from long-term care homes and organizations, LHINs, clinical subject matter experts and quality improvement organizations will help to improve residents' experience, decrease adverse events, decrease transfers from long-term care to hospitals and increase the satisfaction of residents, families and staff.

Building internal capacity

Having completed our strategic plan at the mid-point of 2008/2009, OHQC set out to develop the staff capacity to deliver on our four strategies. The organization grew from six to 11 staff during the fiscal year. We added new skills in quality improvement and performance measurement, and strengthened our communications capacity. To meet our expanded reporting responsibilities, we further enhanced the research and communications functions by adding four more staff in early 2009/2010. This growth challenged OHQC to find larger accommodations. By year-end, we had secured and furnished a new location with a six-year sublease arrangement at below-market rates.

Ensuring fiscal responsibility

OHQC has continued to fulfill its mandate to the fullest while exercising fiscal prudence under appropriate governance by its board of directors. The agency receives all of its funds from the Ministry of Health and Long-Term Care, plus interest earned on these funds. Anticipating a budget surplus, the Council returned $100,000 to the Ministry in the fourth quarter.

OHQC finished the year with a surplus of $290,644. Compared to the budget set out in the Ministry's funding letter, and in keeping with board-approved budget modifications, administrative costs were about $415,000 greater than originally allocated due to the need to expand accommodations, as noted above. Research and communications activities were under budget by about $185,000 and $408,000, respectively, because some projects were scaled back. We underspent by $82,000 on special projects, since we delayed hiring for long-term care reporting until we received funding confirmation in the last month of the fiscal year. Compared to the previous year, total spending increased by about $250,000, of which about $140,000 was for additional special projects.

Impact

As in previous years, the release of the 2009 edition of *QMonitor: Report on Ontario's Health System* generated extensive, sustained, accurate and high-quality coverage in print, television, radio and online media, provincially and nationally. Although the release took place in the first quarter of 2009/2010, almost all of the work to produce it was completed in the 2008/2009 fiscal year.

Performance measures presented in the table on the next page indicate that, compared to the 2008 report release, there was a slight increase in audience reach for mainstream media and a significant increase (88%) in audience reach for on-line coverage. Of particular note was the media attention given to the 10 healthcare provider success studies featured in the report and on OHQC's website, which support the spread of best practices. Also noteworthy were the public statements issued by the Ontario Hospital Association, the Ontario Long Term Care Association and the Ontario Medical Association in response to the report.

OHQC's emphasis on the interplay of measurement, public reporting and support for quality improvement is having an impact on those who make decisions affecting Ontario's health system and quality of care. Examples include:

- Two hospitals — Trillium Health Centre and The Ottawa Hospital — have publicly committed to improve wait times for urgent cancer surgery and set targets:
  - Trillium Health Centre has committed to increase compliance for priority 2 and priority 3 cancer surgeries from current levels of 73% and 83%, respectively, to 95% by March 2010; President and CEO Janet Davidson has urged other hospital CEOs to follow suit
  - The Ottawa Hospital has committed to improve wait time compliance for urgent breast, colorectal, lung and prostate cancer surgeries to 80% by March 2010
- OHQC leadership of the Access component of the Ministry's Quality Improvement & Innovation Partnership (a quality improvement program for Family Health Teams) achieved a significant reduction in wait times among the 45 teams in the first cohort,[1] and the second cohort is showing early signs of improvement
- The Ministry, LHINs, healthcare provider associations and organizations are increasingly seeking advice and assistance on performance measurement and quality improvement from OHQC
- OHQC's nine attributes of a high-performing health system are being adopted by more and more health-related organizations, including the Health Council of Canada, most LHINs and a number of healthcare providers, as their framework for planning and reporting to the public

[1] The average wait time for the third next available appointment steadily declined from 17 days in June 2008 to 10 days in May 2009. The wait time for the first and second available appointments can be skewed by chance cancellations, so the third next available appointment is a more reliable reflection of true wait times.

Performance Measures

Objectives	Performance Measures	Spring 2006	Spring 2007	Spring 2008	Spring 2009
Continue to build public awareness of OHQC and its report	Public awareness of OHQC[2]	6%	9%	9%	10%
	Public awareness of OHQC report[2]	N/A	16%	10%	11%
	Media coverage (newspapers, radio and television)	100 media hits with a reach of 2.0 million people	140 media hits with a reach of more than 4.4 million people	158 media hits with a reach of 12.8 million people[3] and 188 million impressions online[4]	133 media hits with a reach of 13.3 million people[5] and 354 million impressions online
Provide objective and accessible information on healthcare system quality and performance	Percentage of public who are aware of OHQC and consider it a trusted, independent voice[2]	N/A	N/A	46% agree, 6% disagree, remainder are neutral or don't know	42% agree, 10% disagree, remainder are neutral or don't know
	Extent to which media coverage aligns with OHQC key messages[6]	N/A	90%	100%	100%
Educate and inform Ontarians about the performance of the publicly funded	Website visitors and report downloads following release	In three months following release, there were 2,000 website hits and 1,400 report downloads	In three months following release, there were 6,500 website visits and 2,600 report downloads	In two months[7] following release there were 6,326 website visits and 3,825 report downloads	In two months[8] following release there were 9,959 website visits and 5,496 report downloads
healthcare system through *QMonitor: Report on Ontario's Health System*	Phone/email requests for report in three weeks following release	N/A	155	267	82

[2] Data source: Telephone survey of 1,000 residents across Ontario, conducted through third-party omnibus poll.

[3] For mainstream print, television and radio coverage.

[4] Figures have been updated from OHQC's 2007/2008 annual report to standardize methods for calculating reach.

[5] For mainstream print, television and radio coverage.

[6] Performance in 2007 was assessed through the Canadian Public Relations Society's media relations rating system. In 2008 and 2009, all broadcast and print media coverage was completely "on message" so we did not repeat the formal assessment.

[7] May 20th to July 15th.

[8] June 9th to August 4th.

OHQC Governance and Management, as at March 31, 2009

Under the regulations related to the *Commitment to the Future of Medicare Act, 2004*, the affairs of the Ontario Health Quality Council (OHQC) are governed by the Council members, appointed by the lieutenant governor in council, acting as the agency's board. The Deputy Minister of Health and Long-Term Care or his/her designate sits as a non-voting ex-officio member. At least one member is cross-appointed to both OHQC and the Health Council of Canada.

A key change in OHQC's governance occurred in the final month of 2008/2009, with the retirement of the inaugural Council chair, Raymond Hession, and the appointment of Council member Lyn McLeod to this position.

Ontario Health Quality Council board of directors, as at March 31, 2009

Dr. Arlene Bierman (Toronto), Chair, Performance Measurement Advisory Board

Shaun Devine (Waterloo), Chair, Management Resources Committee

Paul Genest (Ottawa), Chair, Communications Committee

Victoria Grant (Stouffville), Council Vice-Chair

Dr. André Hurtubise (New Liskeard)

Lyn McLeod (Newmarket), Council Chair and Provincial Representative to Health Council of Canada

Andy Molino (Ottawa)

Dr. Janice Owen (London)

Laura Talbot-Allan (Kingston), Chair, Audit and Resources Committee

Governance structure in support of OHQC's board

Audit and Resources Committee:
Laura Talbot-Allan (Chair), Shaun Devine, Andy Molino

Communications Committee:
Paul Genest (Chair), Dr. Janice Owen, Dr. André Hurtubise

Management Resources Committee:
Shaun Devine (Chair), Lyn McLeod, Victoria Grant, Paul Genest, Laura Talbot-Allan

Performance Measurement Advisory Board:
Dr. Arlene Bierman (Chair), Dr. Janice Owen and expert members appointed by the Council's board

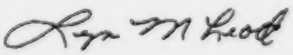
OHQC management team

Dr. Ben Chan, Chief Executive Officer

Angie Heydon, Chief Operating Officer

Eileen Patterson, Program Director, Quality Improvement

Ontario Health Quality Council
Annual Report 2008/2009
Approved by:



Lyn McLeod, Chair

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AUDITORS' REPORT

To the Directors of:
Ontario Health Quality Council

We have audited the statement of financial position of **Ontario Health Quality Council** as at March 31, 2009 and the statements of revenue and expenses, and cash flows for the year then ended. These financial statements are the responsibility of the organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at March 31, 2009 and the results of its operations and the changes in its cash flows for the year then ended in accordance with accounting principles described in Note 2.

Loftus Allen & Co

Oakville, Ontario
May 27, 2009

CHARTERED ACCOUNTANTS
LICENSED PUBLIC ACCOUNTANTS

STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2009
(with comparative figures for 2008)

	2009	2008
ASSETS		
CURRENT		
Cash	**$ 1,131,181**	$ 472,910
Prepaid expenses	**84,925**	–
	1,216,106	472,910
CAPITAL ASSETS		
Computer and equipment	**62,309**	62,309
Office furniture and fixtures	**80,313**	20,313
Leasehold improvements	**229,479**	–
	372,101	82,622
Accumulated amortization	**372,101**	82,622
Net – Capital Assets	**–**	–
	$ 1,216,106	$ 472,910
LIABILITIES		
CURRENT		
Accounts payable and accrued liabilities	**$ 925,462**	$ 271,061
Due to Ministry of Health and Long-Term Care, *Note 3*	**290,644**	201,849
	$ 1,216,106	$ 472,910

APPROVED ON BEHALF OF THE BOARD:

Laura Talbot-Allan, Director

Lyn McLeod, Director

The attached notes are an integral part of these financial statements.

STATEMENT OF REVENUE AND EXPENSES FOR THE YEAR ENDED MARCH 31, 2009

(with comparative figures for 2008)

	2009	2008
REVENUE		
Ministry of Health and Long-Term Care	$ 3,687,000	$ 3,560,742
Ministry of Health and Long-Term Care – special project funding, – *Note 8*	220,900	–
Ministry of Health and Long-Term Care – honoraria, *Note 9*	8,000	–
Interest	24,009	63,355
	3,939,909	3,624,097
ADMINISTRATION EXPENSES		
Salaries and benefits	1,201,775	889,469
Office equipment and leasehold improvements	329,346	856
Rent	69,883	68,237
Computer expenses	58,145	18,022
Council honoraria	53,702	83,693
Publications and memberships	51,563	27,612
Travel	45,079	31,490
Office supplies, postage, couriers and printing	27,205	33,849
Telecommunications	23,131	11,186
Financial services	16,050	16,071
Human resources services	15,815	55,516
Insurance	9,633	7,871
Legal and audit services	8,488	12,264
	1,909,815	1,256,136
RESEARCH	495,500	1,486,107
COMMUNICATIONS		
General communications and web	357,009	241,837
Community outreach	283,591	164,857
Report dissemination	339,314	151,311
Sponsorship	25,000	–
	1,004,914	558,005
SPECIAL PROJECT EXPENSES, *Note 8*	139,036	–
TOTAL EXPENSES	3,549,265	3,300,248
	390,644	323,849
INTERIM RETURN OF FUNDS TO MINISTRY OF HEALTH AND LONG-TERM CARE	100,000	122,000
EXCESS OF REVENUE OVER EXPENSES, *Note 3*	$ 290,644	$ 201,849

The attached notes are an integral part of these financial statements.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2009
(with comparative figures for 2008)

	2009	2008
CASH FROM (USED IN) OPERATING ACTIVITIES		
Cash received from Ministry of Health and Long-Term Care	**$ 3,587,000**	$ 2,508,875
Cash from interest	**24,009**	63,355
Cash paid for administration	**(1,452,324)**	(1,278,357)
Cash paid for research	**(495,500)**	(1,550,659)
Cash paid for communications	**(1,004,914)**	(558,005)
INCREASE (DECREASE) IN CASH	**658,271**	(814,791)
CASH, beginning of year	**472,910**	1,287,701
CASH, end of year	**$ 1,131,181**	$ 472,910

The attached notes are an integral part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2009

1. THE ORGANIZATION

The Ontario Health Quality Council (OHQC) is an independent agency, created under Ontario's *Commitment to the Future of Medicare Act* on September 12, 2005. Its role is to report directly to Ontarians on the quality of the health system and to support its continuous quality improvement.

Its mission is to be "a trusted, independent voice dedicated to informing the public about the quality of its publicly funded health system and a catalyst for improving our health system and our population's health."

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) General
The financial statements are prepared in accordance with Canadian generally accepted accounting principles except for capital assets, which are amortized 100% in the year of acquisition. This policy is in accordance with the accounting policies outlined in the Ontario Ministry of Health and Long-Term Care funding guidelines.

(b) Revenue recognition
The deferral method of accounting is used. Income is recognized as the funded expenditures are incurred. In accordance with Ontario Ministry of Health and Long-Term Care guidelines, certain items have been recognized as expenses although the deliverables have not all been received yet. These expenses are matched with the funding provided by the Ministry for this purpose.

(c) Donated materials and services
Value for donated materials and services by voluntary workers has not been recorded in the financial statements. These services are not normally purchased by the organization and their fair value is difficult to determine.

(d) Capital assets
Capital assets purchased with government funding are amortized 100% in the year of acquisition in accordance with funding guidelines.

During the initial months of operations, furniture and fixtures totalling approximately $28,900 and leasehold improvements totalling approximately $138,900 were purchased directly by the Ministry of Health and Long-Term Care on behalf of OHQC. These assets are on loan from the Ministry and are not reflected in the balance sheet. These assets cannot be disposed of without Ministry approval and are the property of the Ministry and not OHQC.

At March 31, 2009, OHQC was in the process of moving to larger premises and was temporarily occupying two locations. OHQC will return the assets loaned from the Ministry of Health and Long-Term Care when it leaves its original premises on June 19, 2009.

We have treated the signing of the lease as the critical event determining the receipt of goods and services for all rental and leasehold commitments related to the new premises. As a result, we have fully accrued all expenses related to the new premises.

3. DUE TO MINISTRY OF HEALTH AND LONG-TERM CARE

Excess revenue over expenses must be repaid to the Ministry of Health and Long-Term Care unless specific carry-over authorization is provided for all or part of the funds. The amount to be repaid is $290,644.

4. LEASE OBLIGATIONS

OHQC is obliged under a long term property sub-tenant lease, which commenced April 1, 2009 and expires March 31, 2015. The Council was granted access to the unit on March 24, 2009. Annual gross rent under the lease is $170,000. The annual total of rental premises and other obligations during the next five years of the lease are estimated as follows:

	Property	Office Equipment
2010	$ 170,000	$ 5,627
2011	$ 170,000	$ 5,627
2012	$ 170,000	$ 5,627
2013	$ 170,000	$ –
2014	$ 170,000	$ –

5. ECONOMIC DEPENDENCE

OHQC receives all of its funding from the Ministry of Health and Long-Term Care.

6. FINANCIAL INSTRUMENTS

Fair value

The carrying value of cash, accounts payable and accrued liabilities as reflected in the balance sheet approximates their respective fair values due to their short-term maturity or capacity for prompt liquidation.

7. COMMITMENTS

OHQC is committed to contracts with various arm's-length parties over the next period of time to provide services that will enable the organization to fulfill its mandate. These contracts involve future payments for 2010 of $193,650.

8. SPECIAL PROJECT FUNDING

OHQC obtained non recurring funding from the Ministry of Health and Long-Term Care for the 2009 fiscal year. The details are as follows:

	ACTUAL	BUDGET
SPECIAL PROJECTS REVENUE		
Long Term Care	$ 185,900	$ 185,900
Health Force	35,000	35,000
	220,900	220,900
SPECIAL PROJECTS EXPENSES		
Salaries and benefits	19,200	90,000
Education, training and memberships	–	1,500
Office expenses	4,250	5,000
Computer equipment	4,400	4,400
Research	50,000	50,000
Honoraria expenses	6,653	20,000
Office lease	19,533	10,000
Web development	–	5,000
Consultants – Health Force	35,000	35,000
	139,036	220,900
EXCESS OF REVENUE OVER EXPENSES	$ 81,864	$ –

9. MINISTRY OF HEALTH AND LONG-TERM CARE – HONORARIA

OHQC received honoraria to compensate for staff time to serve as faculty for two improvement collaboratives. (A "collaborative" is a series of structured learning events supporting specific projects to improve delivery of healthcare services.) A total of $5,000 was received from the Quality Improvement & Innovation Partnership and the Hamilton Family Health Team. A total of $3,000 was received from the South West Community Care Access Centre for the Partnerships for Health – Integrated Diabetes Strategy. The funding for these two collaboratives originated with the Government of Ontario.

SCHEDULE OF REVENUE, EXPENSES AND BUDGET FOR THE YEAR ENDED MARCH 31, 2009

	ACTUAL	OHQC BUDGET	MOHLTC BUDGET
REVENUE			
Ministry of Health and Long-Term Care	$ 3,687,000	$ 3,687,000	$ 3,687,000
Ministry of Health and Long-Term Care – special projects	220,900	220,900	220,900
Ministry of Health and Long-Term Care – honoraria	8,000	–	–
Interest	24,009	–	–
	3,939,909	3,907,900	3,907,900
ADMINISTRATION EXPENSES	1,909,815	1,725,650	1,494,500
RESEARCH	495,500	879,350	680,000
COMMUNICATIONS	1,004,914	1,082,000	1,512,500
SPECIAL PROJECTS	139,036	220,900	220,900
TOTAL EXPENSES	3,549,265	3,907,900	3,907,900
EXCESS OF REVENUE OVER EXPENSES	390,644	–	–
INTERIM RETURN OF FUNDS TO MINISTRY OF HEALTH AND LONG-TERM CARE	100,000	–	–
DUE TO THE MINISTRY OF HEALTH AND LONG-TERM CARE	$ 290,644	$ –	$ –

Notes

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